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WINTER 1995

Left To Right: Dr. John Collins, Dr. Michael Coppola, Atty. John Bagley
Mark Tolofsky, Honorable Richard Neal

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THE
Hampden Hippocrat
WINTER 1995

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PLACE: **SHERATON SPRINGFIELD**
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DATE: Tuesday, January 23, 1996

BUSINESS MEETING: 6:00 p.m.

SOCIAL HOUR: 7:00 p.m.

DINNER: 7:30 p.m. SPOUSES ARE WELCOME!

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President-Elect, American Medical Association

SUBJECT: AMA Reports On The Issues

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From The Editor

This Winter Issue of the **Hampden Hippocrat** focuses on local issues in managed care. There is a report on the recent forum on the impact of managed care as sponsored by the Hampden County Bar Association and the Society. There are also articles by Dr. John Collins, who has spoken on this topic at Boston University, and Dr. Steward who reports on a managed care phenomenon: The Day Surgery Center.

The changing times seem to call for a reassessment of personal priorities. In this spirit, Dr. Harry Greene has written an essay on balancing the professional and the personal aspects of our lives.

The current Republican-sponsored Medicare reform has passed both houses of Congress with AMA support, but is not in its final form at this writing. Provisions to ensure tort reform are currently *out* again. Medical education, currently sponsored up to 50% of costs by Medicare patients (who are only 15% of the population under care) faces severe cutbacks. Hardest hit will be subspecialty fellowships and international medical graduates who will no longer be subsidized. Hospitals will no longer see expansion of residency slots as a way to increase their Medicare reimbursements. Specialists face cutbacks in reimbursement and primary care physicians will probably see modest gains. A surplus of specialists is predicted as early as the year 2000, with only a modest shortage of primary care physicians, as some of their work is taken on by increasing numbers of physicians' assistants and nurse practitioners.

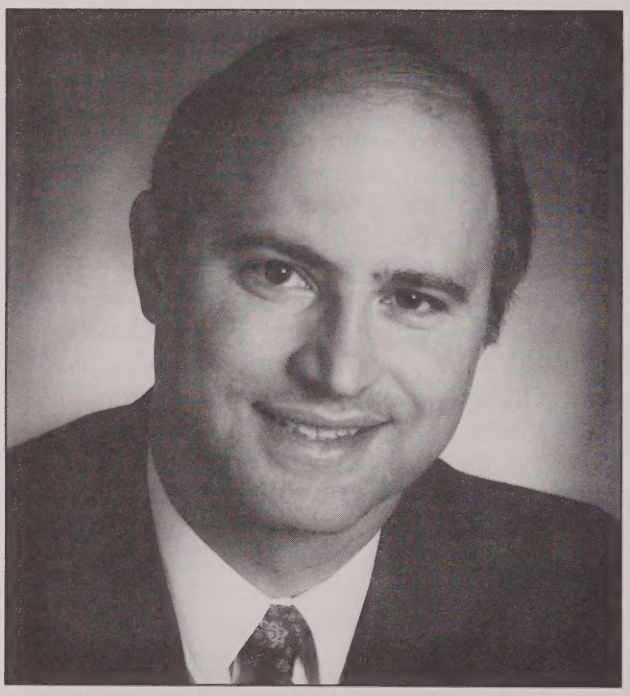
While we may have smugly watched the hospital wars of the past few, highly competitive years, the trend associated with the changes described above is more disturbing. The current climate seems to pit physician against physician in conflicts that are increasingly bitter. Hopefully, as a group, we will be able to maintain our collegial regard and remember our common professional purpose–that is my wish to all of you for the New Year.

Brigid Glackin, M.D.
Editor

The Physician's Dilemma

A radio announcement on August 13, 1995 brought back memories of a night 15 years earlier.

In September, 1980, I was sitting at a bar with Mickey Mantle in the Dominican Republic, just the two of us. A new resort was opening, and the promoters brought in "The Mick" to help sell some units. Somehow, my brother had heard about it and made arrangements for me to go to this Caribbean island and meet a childhood hero. Due to a poorly organized publicity campaign and dumb luck, only two Americans showed up on Saturday, Mickey Mantle and me! A large number of American investors were coming on Sunday to play golf with Mickey, but on Saturday night and Sunday morning, we were the only two men in the resort who spoke English. We were introduced and after supper, I saw him sitting alone at the bar, drinking Rusty Nails (Scotch and Drambuie). I pulled up a chair and he was very gracious, telling some stories that I hadn't heard before, and some I had, and he kept ordering Rusty Nails. Finally, I decided to emulate my idol, and also asked the bartender for a Rusty Nail. "I'm sorry, sir, but I can't serve you." he replied. Shocked, I didn't know what to say. I was 27 years old and clearly of age; the language barrier, I presumed, was the problem, and so I tried again. "I'll have the same thing he's drinking," pointing to "The Mick". This time, it was the bartender who was embarrassed. "Sir, I cannot serve you that drink. I have run out of Scotch."



John Papale, M.D., President

The Mick had cleaned them out. Fourteen years later, I read and reread the cover story in the April 18, 1994 issue of *Sports Illustrated*. On August 13, 1995 as I listened to his death announced on the radio, I was reminded of how the *Sports Illustrated* article spoke not only of his alcoholism, but also of how it affected his personal life and in particular his disappointing relationship with his sons.

Four days earlier, we learned of Jerry Garcia's demise, another icon whose personal struggle

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with substance abuse was never hidden. While many things could be learned from these untimely deaths, the tragedy of their personal lives continues to haunt me. How could these two men have had such successful careers (seemingly without effort) and such tragic personal lives? How many successful people are subject to this same curse?

While drug and alcohol abuse certainly exist in the medical community, we are all prone to a more insidious disease: the intoxication of success. Our prestige is great, our jobs can be immensely gratifying, and we are well-paid. The rewards, in fact, can be so great that they become intoxicant. Sometimes we can devote so much time and energy to our work, that often we are physically and emotionally drained by the time we get home or when the weekend arrives. We make sure our CME is updated, but what about our CPE (Continuing Personal Education)?

Fortunately, we do have immense control over our professional careers, and we can put balance back into our lives if, in fact, it's needed. We need to be constantly on guard to make sure we always maintain the balance between our personal lives and professional careers. ■

Dr. John Papale and Mickey Mantle, September 1980

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Impact Of Managed Care

by Brigid Glackin, M.D.

The fourth annual joint meeting of the Hampden District Medical Society and the Hampden County Bar Association convened at the Delaney House on November 2, 1995. Approximately 175 people were in attendance, with a slight predominance of lawyers. The format was a panel discussion in which panel participants made 8 minute didactic presentations. Following this, the panel answered questions from the audience.

Richard Neal, Congressman from the 2nd Congressional District, led off with his views on Medicare and the impact of managed care, as proposed in current legislation, on that program. Neal expressed the view that Medicare is a contractual obligation from generation to generation. He expressed satisfaction with the achievements of the program and a concern that managed care is "not for everybody". While he agreed that fiscal changes are needed in Medicare, he suggested that we "do it gingerly".

Mark Tolotsky, CEO of Baystate Medical Center then summarized the impact of managed care from the point of view of a hospital administrator. He stated that we "haven't really seen - managed care yet", in Western Massachusetts, despite the fact that the state has one of the highest penetration rates of HMOs and PPOs. There has been a restructuring of how health care is financed in Western Massachusetts but little change yet in how it is delivered. He predicted a shift of significant control into the hands of primary care physicians. He also anticipates a realignment of incentives and a limitation of access to providers. Baystate Medical Center is preparing for capitation which will change the emphasis from caring for the sick to keeping people healthy. Instead of celebrating increases in emergency room visits and admissions, in the future, hospitals will celebrate decreased hospital admissions below what was budgeted in capitation formulae. Current incentives can promote

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"excessive utilizations". He suggested that providers need to "climb up the revenue stream and become more involved in insuring and financing care."

John Collins, formerly medical director of Medical West, and now an administrator with Blue Cross-Blue Shield opened his presentation with a definition of managed care. He defined it as an integration of health care financing and delivery. This ends the direct relationship of patient and provider with insurance paying all the bills. The current large managed care organizations in Massachusetts include Harvard-Pilgrim: 800 thousand; Fallon Health Plan: 170 thousand; HMO Blue: 600 thousand; and Tufts; 260 thousand.

In Dr. Collins' view, managed care has caused the reduced use of specialists and the development of one day surgery. Surveys suggest that patient satisfaction has increased. Practice standards have developed. However, managed care is part of a movement toward market driven health care. The threat is that this will undermine patient trust, expand the number of patients who have no coverage, and undermine medical research. Incentives in managed care can result in skimming off healthy patients and rationing health care delivery. However, Dr. Collins feels the potential for conflicts of interest exist in all forms of health care. Dr. Collins asks, "Do we have sufficient resources to avoid rationing? Can we provide health care for all? I hope the answer is yes."

Attorney John Bagley then addressed the legal implications of managed care. He feels there is a definite risk of increased liability. Lawyers locally and nationally are studying managed care arrangements as they evolve and mature. Kaiser, which requires mandatory arbitration (as part of their patient contract) for malpractice claims, is being challenged in the California courts. Attorney Baggley predicts claims of charitable immunity by HMO organizations will also be challenged. He expressed surprise that physicians *currently* were obsessed with quality of care issues in managed care, rather than liability issues.

Michael Coppola addressed the issues of managed care from his perspective as a member of a large, multispecialty medical group, allied with a home care company, which is forming a network with other groups of primary care physicians in Springfield. Dr. Coppola stated that the premise of managed care, that by controlling

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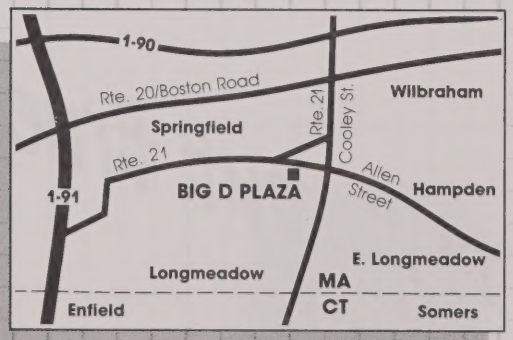

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Impact Of Managed Care

Continued from previous page

dollar flow we can adjust behavior, is flawed. He feels that as physicians we were taught to do the best we can and in general the most we can. He notes that Hillary Clinton predicted that market forces would proceed with health care reforms, whether the government acted or not. She also predicted managed care would put more power in the hands of physicians.

Dr. Coppola sounded an upbeat note when he suggested that the current changes in health care offer risks, challenges, and opportunities. He feels that the patient choice of physician, based on a physician's reputation, will be lost. Managed care plans themselves will develop their own reputations. The risk of capitation is that the physician will do the minimum. Medical decision making will be altered. The challenge is to develop patient practice standards to optimize care. Managed care will put utilization review in the outpatient arena, an area that is currently largely unscrutinized now.

Dr. Coppola opined that physicians can save managed care money and define quality. Hospitals will inevitably lose power. There will be more primary care and less specialty care.

A question and answer session followed. Dr. Joseph Keenan reflected that the changes we see are similar to changes in the Middle Ages when guilds which controlled the production of products by artisans or professionals lost their hegemony to businessmen. Non-physicians in the audience expressed concern about the impact on medical education and research. John Collins suggested that currently specialists deliver care "where they don't add value" and that primary care physicians deliver care that could be as effectively done by nurse practitioners or physicians' assistants. He noted that physicians don't reach consensus and they don't like to become involved in management. Mark Tolofsky worried that the "dollars can't afford to support the technology we have today". Richie Neal had the last word when he said that doctors don't do as well in Washington today as they did 25 years ago and he blamed that on a loss of intimacy in doctor-patient relations including the end of the house call. ■

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Basic Concepts In Managed Care – One Viewpoint

by John A. Collins, Medical Administrator
Medical West Associates

While preparing to speak to the first group of physicians participating in the Blue Cross-Boston University School of Medicine co-sponsored Primary Care Physician Retraining Program about "Basic Concepts in Managed Care," Dr. John Papale asked me to share some thoughts about managed care with Hippocrat readers.

One of the references being used for the discussion at Boston University School of Medicine is John Inglehart's, "Health Policy Report" in the New England Journal of Medicine, dated September 1992, about managed care. This article suggests that managed care is a system which integrates health care delivery and financing through the use of selective contracting with physicians and hospitals, the use of pre-payment often with capitation, the use of utilization and quality parameters and often the use of financial incentives and the assumption of some financial risk by physicians, institutions, etc.

Most would agree that cost has been the prime motivation behind the push toward managed care.

It's hard to be an active practitioner today and be unaware of these fundamental principles of managed care. Although a relatively recent phenomenon, it is difficult to ignore the other changes that have followed the increase in patients covered by managed care programs. The decline of Medicine as a "cottage industry" has resulted in physicians increasingly coming together in single and multispecialty groups. Groups of physicians are coming together to form Physician Hospital Organizations while hospitals are merging, downsizing and forming integrated delivery systems.

Most would agree that cost has been the prime motivation behind the push toward managed care, especially as our technologic ability advances and we train more and more specialists to care for an aging population anxious to maintain the "good life" for as long as possible. At the same time, it's hard to ignore studies that suggest a significant subset (25-40%) of medical services are unnecessary or wasteful. It is equally troublesome to acknowledge that there is significant variation in practice to a degree that is not explained by patient characteristics. This variation in care often occurs with common conditions such as pediatric immunization, Cesarean Section, Diabetes care or use of cardiac catheterization.

It is easy to become convinced that managed care is only about the cost of medical care. A closer look strongly suggests that the most innovative systems around the country are working within the managed care environment to demonstrate the value of the health care services the organized system delivers. Over twenty managed care systems across the country have made a considerable effort to identify, report and improve their performance on a series of measures known as HEDIS measures (Health Employer Data Information Set). These measures include pediatric immunization rate, mammographic screening rate, cholesterol screening rate and the rate of retinal exams in patients with Diabetes. In Massachusetts, the State Medicaid Program has developed a very proactive program with its contracting HMOs whereby the HMO performance on a series of quality goals involving mutually negotiated improvements in the quality of medical care delivered to Medicaid patients. This initiative resulted in Medicaid deciding to stop contracting with HMOs earlier this year. The Massachusetts Health Purchaser's Group, a coalition of over 70 employers with over 1,000,000 employees, has adopted a similar Quality Goals approach with its HMOs as well. The managed care organizations are responding to these challenges in ways that ultimately improve patient care and have, in several areas, significantly improved care delivery. Certainly we are now able to coordinate care in a much more

sophisticated way than previously. Use of Home Care for Infusion Therapy at home, use of Respiratory Therapy at home permits patients and their families to manage effectively at home with nursing support. When combined with emotional support and counseling in the Hospice Programs, supportive care can be delivered in the comfort of the home eliminating the risk of nosocomial infection and permitting patients to be in familiar surroundings and with family around.

Managed care has had a dramatic impact in the area of case management, where specific resources are used to comprehensively manage complex cases in a high quality and cost-effective way. This often involves going significantly beyond the standard insurance benefit package. In addition, managed care programs are opting for disease management programs where computer system support is used to assure that indicated services are provided to patients with a particular disease. A diabetic disease management program would monitor medication compliance, regularity of retinal exams, monitoring of laboratory parameters such as Hemoglobin A1C and renal function. With the Medicare population, managed care programs routinely measure and seek to optimize functional status, provide outreach practitioners to help coordinate care and do home visits if appropriate. In addition, multiple different levels of care are often available including acute hospital, rehab hospital, rehab at Skilled Nursing Facilities, skilled care and residential supervision, along with various levels of home care. In addition, social workers are available to be sure that other necessary non-medical services are available. It's hard to imagine managing to cut Medicare expenditures dramatically and manage an ever increasing population of Seniors without this approach.

Finally, managed care has focused on delivery of outpatient care and common health conditions. Efforts have been directed at intensive management of high risk pregnancies with demonstrable reductions in premature births. Significant reductions in rates of Cesarean Section have been achieved, asthma care for children has been improved by combining patient and family education with use of peak flow meters, updraft and use of inhalers, especially steroid inhalers. In addition, managed care programs have supported weight reduction programs, exercise, nutrition and smoking cessation programs.

Still, much more needs to be done as our ability to manage the care our patients receive improves. One of the tool kits that has become increasingly valuable in the effort to improve the process of care is the use of the techniques of Total Quality Management Continuous Quality Improvement. More on that next time! ■

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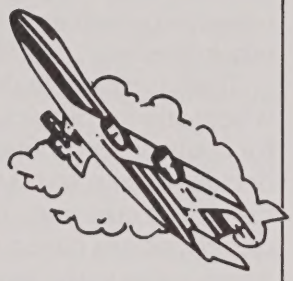

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The Physician Juggler

by Harry L. Greene, II, M.D., Executive Vice President
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"I just don't have enough time," is a lament that we often hear from our colleagues and often reflect to ourselves as we go about our busy, other directed, crisis to crisis living.

Time, is clearly in decreasing supply everywhere and for physicians it may be worse than for many other professions. If a business man decides that he wants to put off a customer, he may lose a customer, but the customer will not die. Physicians have to deal with certain realities which relate to the importance of their work. Medical student training and residency training encourages one to be "other directed." This pattern can often extend beyond the residency years and can become a pattern for life. In previous generations when the work of home building and child rearing could be segregated between parents and one was less likely to have a two professional family, the total immersion of one individual in his or her career and the other in the home was a common phenomenon. But, this scenario is a reflection of a bygone time. Now more and more physicians are marrying other physicians or professionals. We are spending more time on the job than before and we are having to cope with new issues such as medical economics and politics, capitation and managed care, which did not appear in the curriculum and are being taught out of necessity by our day to day living. For many, this type of life leads to a survivalist mentality. Under this mentality, one simply tries to take care of each issue as it appears before us without really prioritizing and with the simple hope of surviving.

This type of a lifestyle and approach to problem solving for many can be exhausting and can lead to mid-career burn out or dissatisfaction with one's chosen career or an alienation of family and other important people in one's life.

Although this sounds depressing, there is hope. During my years in the practice of medical oncology, it became obvious to me that people who had discovered that they had cancer and that their lives were finite behaved in very different ways. In general they divided themselves into two groups: there was those individuals who changed many, many things about the way they were living and there were others who changed very little. It seemed to me that I would prefer to be in the later group. That is, those individuals who are living their lives now the way they wanted to, rather than waiting till their life was almost over.

In some studies that we did over a decade ago looking at nearly four thousand physicians in various types of practice settings, it was discovered that those who were regularly taking time to assess their own life goals, doing this on a weekly or monthly basis, and writing the goals down were not only better off financially, but also were much more satisfied with their professional and personal lives. Much data in the non-physician time management literature had supported this concept as well, so, it seemed that one of the fundamental principles was taking time to do some goal setting.

Those who teach about goal setting encourage us to do it in all aspects of our lives from the spiritual to the philosophical and from the economic to the personal.

Having done this, one is faced then with the issue of priorities. How do these various goals stack up against each other? How does one make a decision about which one or ones to approach and how to go about doing it?

For most of us, this is the most personal aspect of the process of regaining control of your life. One has to be brutally honest about what you truly enjoy, what you are good at and what brings you satisfaction and self-esteem. Do you like

interacting with patients? Is this the most important thing to you? Is research important? Where does your family fit in–or your significant other? Physicians, who tend to be extremely hard workers, chronic over achievers, and given to delayed self-gratification, often have difficulty making these kinds of choices, but sooner or later, whether they choose to or not, the choices are made and often they are made without much thought.

There are a number of systems available to help one establish priorities, varying everywhere from a simple ABC method such as that advocated by Alan Lakien, to an economic approach (Stephanie Winston) (e.g. find the thing with the biggest financial payoff and focus on it), to the more complex but important prioritization based upon the roles that one plays in life. (Stephen Covey).

On a personal basis, I've preferred using a role priority system as the best overall approach. Before using that, I was often placed in a dilemma of choosing between patients and my family. Going to a patient's home for a home call versus seeing a child's soccer game, going to the emergency room versus attending a graduation.

If one uses a role prioritization system, for example, my role as parent is most important or my role as physician is most important and then share that information with the important people in your life, they will be more likely to understand when you make a choice that leads in one direction or the other.

Once the goals are established, and a priority is instituted, it's essential to translate large global goals into observable, achievable sub-projects.

For grant writers, these would be called objectives. But they are eventually broken into smaller, specific objectives that can be measured and quantitated and at the end of the day one can look back and say, "Yes, I accomplished this or no I didn't."

I often encourage people to take stock of how they are currently using time. One simple way to do this is to keep a time log for a couple of weeks and through a couple of weekends noting everything that one does. While this seems a bit fastidious and perhaps obsessive, not to do it causes one to miss many interruptions, distractions and other activities that may not be listed on the planned calendar for the week. It also gives one the opportunity to intervene in areas where time may not be optimally used. It is also worthwhile

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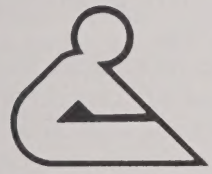

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The Physician Juggler

Continued from previous page

to ask the other people around you how you can work together to increase the efficiency and effectiveness of each other. They often may have ideas of things they can do to help you and preserve time and efficiency for both of you.

One of the biggest time savers is the ability to say no. Saying no is enhanced by the knowledge of one's own goals and priorities and taking the time at least 24 hours before saying yes to a new request to figure out where it fits into one's life plan and if it is really something you want to do. Many of us are pulled into time quagmires by saying yes without taking time to think about it. Most of us are concerned about offending others. In particular, physicians, who have a special calling to help others, have a great reluctance to say no. Nonetheless, of all the techniques, this is probably the most important in terms of maintaining one's time for self. Another major area or problem which may be improved in the future is the management of paper. The amount of paper that physicians deal with increases ten fold about every three years. We are reaching the point now where we are virtually strangled in our offices by the amount of paper work, reviews, second guessing, requests, prescriptions, and so forth, that require paper and pen.

The good news is the technology is available to create the paperless office and for those who are moving in that direction, new efficiency and effectiveness can be obtained. It's important as you go through a time management exercise to think about everything you are doing. What do I really need to do, what can appropriately be delegated, what can be streamlined and more importantly, what does not need to be done at all.

In delegating, it is important not to give away those things which one enjoys or which enhance one's enjoyment of the profession. During a brief period in my life, I worked with nurse practitioners in a way in which they took the history and did a great deal of the patient interaction. This left me feeling more like a technician than like a physician and taught me an important lesson about my personal need to spend time with patients talking with them and interacting with them to fulfill my needs as a physician. Once one has established goals, priorities, and has done a time log to look at how one is currently using time and has begun to say no, delegate and do things in a more effective manner; we need to begin to use our calendars to help support this time management program. One way to do it is to set aside time and space for those issues we consider to be priorities. For example, in starting the day, if we have a goal which includes exercise somewhere on the calendar should be a chunk of time reserved for that exercise program. By placing it on the calendar and guarding the time, you are indeed turning your priority into a reality. When you look back over your calendar for a week or two weeks or even for a month, your schedules should reflect your priorities. If it doesn't, you need to go back and start again.

Taking time for self-renewal is an important concept for people whose customers come to them with "complaints". In the airline industry, those customer service representatives that deal with complaints on a constant basis are rotated out of the front line periodically throughout the day to catch their breath. In fact, in virtually all customer service areas, this is a standard practice. In business they learned a long time ago that not to allow people time during the day and blocks of time at other periods of the week or month leads to burn-out and increases personnel costs. Burned out physicians are ineffective, they're inefficient, they make mistakes, they may be cynical and may be dangerous to their patients and to themselves. To be productive one must take time for self-renewal.

The longer work days, the increasing complexity of what we do on both an economic management and clinical basis make it imperative that we maintain our communications with the other important people in our lives. To do this, we must cultivate an environment in which those around us understand the need for us to maintain our linkages, to have time for self-renewal and continue our medical education and to simply have some periods of quiet time for contemplation and reflection.

While all this sounds incredibly simplistic, it is not easy. Our intelligence, interest in others, inquisitiveness, desire to please and satisfy others make staying with our own goals and priorities a challenge. To be successful, one must recommit and re-evaluate and re-align over the course of one's lifetime. There is a Spanish proverb which says, "Tienes que dar tiempo al tiempo." One must give time to time. ■

Hampden Committee Activities

The **PUBLIC HEALTH COMMITTEE** met in September. **Mr. Jay Breines,** Executive Director, and **Mr. Kevin Hamel,** Program Development Coordinator for the Holyoke Health Center, were our invited guests. Mr. Breines reviewed the background of the Health Center, which is twenty-five years old. The Health Center has a satellite clinic on Maple Street in Holyoke and utilizes the pre-natal center at Providence Hospital. The Center services a large Latino population and provides health care to the Holyoke/Chicopee inmates of the Hampden County jail. The Center participates in an HMO called the Neighborhood Health Plan. The plan has the largest Medicaid population in the Commonwealth. Two of the most prominent health problems seen at the Center are asthma and diabetes. This summer, the Center, working with the Holyoke Boys and Girls Club, established a community center in a public housing unit in the "Flats" section of Holyoke. The community center helped to bring some fun-filled activities and programs to the children who live in this section of Holyoke. Also an immunization drive was held in conjunction with Holyoke Hospital and Holyoke Pediatrics. Any child with complete immunizations records was invited to a party at the Holyoke Children's Museum. This was done with hopes that children who were not fully immunized, would become so in order to attend this party or any future parties. Mr. Breins asked for a letter of support in the Holyoke Health Center's bid for renewal of their Section 330 Program funding. The committee said they would gladly send a letter of support.

The **MEDICO-LEGAL COMMITTEE** met in September to finalize plans for their November 2nd forum titled "The Medical, Legal and Societal Impact of Managed Care". Panelists chosen to participate in the round table type discussion are: **Congressman Richard Neal** representing government, **Mark Tolosky**, CEO at Baystate, representing health administration, **John Collins, M.D.** representing insurance, **Attorney Michael Mone,** representing law, and **Michael Coppola, M.D.,** representing medicine. **Keith Silver** will serve as moderator.

The **EXECUTIVE COMMITTEE** met in September. **The Hampden Hippocrat** has gone to a seasonal, four issues a year, format. The committee discussed the need for an increase in advertising rates and an increase in the number of advertisers. There will be further discussion on ways to improve the content of the magazine, generate more contributing writers, and increase circulation.

Our seventh **HOUSE CALLS** program was held on September 17, 1995. The topic was Prostate Disease and Prostate Cancer. Several area urologists and oncologists participated. Free prostate screening clinics were held in conjunction with this program.

Our **DISTRICT DINNER MEETING** was held at the Delaney House on September 19, 1995. One hundred and three members, spouses and guests attended. **Dr. Guenther Spanknebel**, President of the Mass. Medical Society, spoke on membership recruitment. To help Dr. Spanknebel in his recruitment campaign, several of our members brought non-members as their guests. **Dr. Harry Greene**, Executive Vice President of Mass. Medical Society, gave an excellent presentation entitled, "To Seize The Day: Time Management For Today's Physician". Dr. Greene has written an article pertaining to his presentation in this issue of the Hippocrat. If you were unable to attend our District meeting,please take a few moments to read his article.

One hundred and thirty health professionals attended our **ELEVENTH ANNUAL MEDICAL ETHICS SEMINAR**, held on October 18, 1995 at Mercy Hospital's Deliso Center. **Dr. Michael McCabe**, from Memorial Sloan-Kettering Cancer Center, spoke on "A Goal Centered Approach to End of Life Decision Making". The panel consisted of **Ann Franczyk, R.N., Roy Stillerman, M.D.,** and **Rabbi Herbert Schwartz**. ■

A Hampden County Address!?

"Fourscore and seven years ago our fathers..." first documented the successful practice of ambulatory surgery in an article published in the *British Medical Journal*. J. H. Nicoli of Glasgow reported in 1909 that the success rate of nearly 9000 outpatient procedures was no different than that for inpatients[1]. Over the last 25 years, ambulatory surgery has been rediscovered. Today an estimated 60% of all surgical procedures performed in the United States are done on an ambulatory basis. Anesthetic, surgical and pharmacological advances have drastically increased the types and complexity of operative techniques that can be performed on an outpatient basis. These same advances have also greatly expanded the pool of appropriate patients for these procedures.

As an anesthesiologist, I was exposed to the many advantages of this form of surgical care and I developed a strong interest in outpatient anesthesia and surgery. After close involvement in the recreation of an "in-hospital" day surgery unit, I decided to truly specialize in this field by accepting the position of Medical Director and anesthesiologist at Maple Surgery Center, a freestanding ambulatory surgery center in Springfield, Massachusetts. Cutting the umbilical cord from the hospital, nearly ten years ago, was a traumatic event. To practice a specialty which, by necessity, severely trespasses upon and compromises a patient's homeostasis, without the security of all that a hospital provides right down the hall, was an emotionally challenging decision. I, and others before me, however, saw an opportunity to provide a better environment for our patients, and this outweighed any personal loss of security.

One of the reasons for writing this article was my realization that very few medical professionals, outside of those whose practice directly involves outpatient surgery, are aware of the advantages, if not the existence, of freestanding ambulatory surgery centers. Most physicians become intimately familiar with the hospital environment during their training and, depending on their specialty, may never be exposed to a freestanding surgery center. The exceptions to this, of course, are those "lucky" individuals who have been patients at these facilities themselves.

A freestanding ambulatory surgery center, such as Maple Surgery Center, is a specialized facility that is able to focus all of its priorities upon providing the highest quality care of patients undergoing elective ambulatory surgical procedures with the most efficient use of resources possible. Patient and physician acceptance of freestanding surgery centers has been earned and continues to be earned every day. Patient safety is paramount. Centers need to understand the limits of their scope of patients and procedures and be prepared for all contingencies encountered during surgery. In Hampden County, and in general, their track record in this area has been outstanding.

Other aspects are important as well. A smaller environment means patients can park closely and efficiently and won't feel lost in a maze of corridors once inside the building. Admission is expedited by dedicated personnel and patients appreciate the high degree of one-on-one care and the low key, less stress inducing, ambiance that is often not reproducible in a hospital environment where seriously ill and more medically complicated patients are cared for. Surgeons, in turn, appreciate a highly efficient team that is proficient with all of the equipment, is motivated to provide a short turn-around-time between cases and goals are often easier to accomplish in a smaller environment where staff morale is easier to maintain, the number of different pieces of equipment is less, since the scope of procedures is smaller, and where there is generally less bureaucratic red-tape involved in staffing and purchasing issues. Also an operating room schedule that is not frequently changed because of emergencies makes for more efficient use of surgeons' and patients' time.

Long before terms like managed care, price controls and cost containment became commonplace in medical dissertations, freestanding ambulatory surgery centers, with their small environments, were developing better ways to bring the most efficiency out of each health care dollar. Fixed costs, including rent and utilities are frequently less in a smaller, more focused environment and a preset operating room schedule allows for very efficient staffing.

Quality of care issues are no different for freestanding centers as they are for other health care

institutions since they are held to the same standards of care. Accreditation by the Joint Commission on Accreditation of Healthcare Organizations, as obtained by Maple Surgery Center, is a demonstration of excellence in the area of quality care, just as it is in the hospital environment.

Freestanding ambulatory surgery centers provide safe, cost efficient surgical care. In light of today's political climate regarding health care costs and the increased importance of getting the most for our patients from the available health care funds, I feel these outpatient centers are going to be an increasingly important part of medicine in the future. We, as health care professionals, should be as informed and familiar with this newer class of institution as we are with our inpatient facilities, during this period of momentous change in the practice of medicine.

I will close with another excerpt from President Lincoln's Gettysburg Address (with all due apologies) that is as well suited to medicine today as it was to the country in 1863. "It is rather for us to be here dedicated to the great task remaining before us...."

Anyone who is interested in more information or touring Maple Surgery Center should contact me at the number below. ■

Russell R. Steward, M.D.
Medical Director/Chief of Anesthesiology
Maple Surgery Center
298 Carew Street
Springfield, MAS 01104
(413) 739-9668

References

1. Nicoli JH: The surgery of infancy. BR Med. J 2:753, 1909

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In Memoriam

Dr. Agostino Natale, 67, of Springfield, died Monday, October 23, 1995, in Formia, Italy, while vacationing with his wife, Joan (Barry) Natale. He entered private general-surgery practice in 1960, and maintained offices in Enfield and Springfield until 1989. He served on the staffs at Baystate Medical Center and Mercy Hospital, and was a consulting staffer at Municipal Hospital.

He became the first medical director of Health New England in 1986, and played a key leadership role in bringing together area physicians and hospitals to create the area's first provider-owned health maintenance organization. After retirement last year, he stayed as a consultant.

He was appointed assistant city physician in 1965, and a full-time city physician in 1985. After retirement, he remained associate city physician on a contractual basis.

He served on the indeminification boards of the city's Fire and Police Departments and Retirement Board. He was a consultant to the Health Department.

From 1976 to last year he was a trustee at Municipal Hospital, and was chairman for a term.

He was senior clinical instructor in surgery at the Western Campus of the Tufts University School of Medicine, and a member of the American Society of Abdominal Surgery, the Hampden District Medical Society, the Massachusetts Medical Society and the American Medical Association.

Born in Caserta, Italy, he was a graduate of the University of Naples School of Medicine. He completed postgraduate training in surgery at BMC, and won a fellowship in cancer surgery at the Westfield State Sanitorium.

He was a major in the Army Reserve, and received a honorable discharge in 1967. He moved here later, and was a communicant of Our Lady of Mount Carmel Church.

He was president of the United Italian-American Society in 1966, treasurer of the Dante Alighieri Society for three years, and a member of the UNICO Club.

In 1974, he received an honorary Cavaliere Della Solidarieta Italiana Award from the Italian Government.

Besides his wife, he leaves two sons, Joseph M. and John C. of Westboro; three daughters, Rosanne Natale O'Hara of Wethersfield, CT, Maria L. Natale of Walpole, and Joanne Natale Gilland of Thomaston, CT, a brother Dominic of Craftsbury, VT and three grandchildren ■

IN APPRECIATION

On the fourth floor of the Mercy Hospital by the entrance to the new special procedure area, there is a large highly visible plaque which reads: "IN APPRECIATION TO THE FOLLOWING CONTRIBUTORS WHOSE GIFTS ENABLED MERCY HOSPITAL TO BUILD THE CENTER FOR SIGHT, THE CENTER FOR ENDOSCOPY AND THE SHORT STAY SURGI-CENTER."

The last four names listed are:

Dr. & Mrs. David L. Marinelli
Dr. & Mrs. Robert H. Dann
Dr. & Mrs. Robert H. Nenninger
Dr. & Mrs. Alan S. Brown

On August 30, 1995, the Mercy Hospital demonstrated its appreciation in dramatic fashion. It announced the termination of its longtime agreement with these physicians and their radiologic associates-a relationship that began with the professional ancestors of the current group more than seventy-five years ago.

By this act the Mercy Hospital clearly demonstrated a commitment to the economics rather than the quality of medical care. The Hospital's behavior shows a total absence of loyalty and support for its staff physicians. The departing group of physicians have provided the finest radiologic services in Mercy's history. This record as well as the many non-medical contributions by this group made no difference in Mercy's decision. The void left by their absence will not be easily filled.

As a longtime member of the medical community and Mercy Hospital Staff I cannot help but sadly reflect on the shocking changes in attitude and ethics over the past several years. Now we have seen a hospital administration repay good with bad. Even the incoming radiologists (one of whom owes her training to the outgoing group) seem to have had no pangs of conscience over the unjust firing of their colleagues. ■

Lawrence N. Metz, M.D.

In Memoriam

Dr. Paul A. Gobeille, 58, formerly of Springfield, died Monday October 9, 1995 in the city's Baystate Medical Center. He was a founder of the Family Care Medical Center on Allen Street, Springfield and retired in 1992. He also was a partner, and practiced in the former Wesson Emergency Association at BMC's Wesson Unit. Born in Springfield, he was a graduate of Cathedral High School and American International College.

He received a doctorate from the University of Pittsburgh School of Medicine, and belonged to Alpha Omega Alpha.

He interned at Mercy Hospital in Pittsburgh, and served his residency at Boston's Lahey Clinic.

He was an Army Medical Corps major in the Vietnam War, and received the Bronze Star.

He was in the Hampden District and Massachusetts Medical Societies, and the American Medical Association.

He moved to Ludlow two years ago, and was a communicant of St John the Baptist Church.

He leaves his wife, the former Jacqueline M. LaPanne; three sons, Paul V. of Jacksonville, FL, Thomas P. of Westfield, and Stephen L. of Springfield; a daughter, Christine A. Gobeille, at home; a brother, Gerrard of Port Charlotte, FL; a sister, Madeleine McKenna of Springfield, and three grandchildren.

Memorial contributions may be made to the American Cancer Society, 383 Dwight Street, Holyoke, MA 01040 ■

Local Girl Scouts Get Look At A Career In Medicine

Girl Scouts in Hampden County got a rare look at life as a doctor thanks to the Girl Scouts of Today-Physicians of Tomorrow Mentoring Program which was launched on Thursday, June 29, 1995 by the Hampden District Medical Society, and the Pioneer Valley Girl Scout Council.

This program developed by the American Medical Association's Advisory Panel on Women Physician Issues and the Girl Scouts of the U.S.A., is being implemented by state and county medical societies across the country in an effort to provide young women with an inside look at a career in medicine. Other sites in Massachusetts launching this program include Lakeville, Waltham, and Worcester.

Participating girl scouts explored their interest in medicine after being matched with a local woman physician who volunteered to host a girl scout for a day on the job.

"Women physicians know the importance of career mentors and female role models," said Alicia O.M. Ross, M.D., Hampden District Program Chair. "The number of women in medicine is growing rapidly, and we hope to see this trend continue. This program is designed to reach out to young women during a time when they are making decisions and choosing paths that will affect the rest of their lives." ■

Standing Left to Right: Kristen Ironside, Brigid K. Glackin, M.D., Claudia L. Koppelman, M.D. Brooke Landry, Grace Makari-Judson, M.D., Betsy Brooks, M.D., Ellen Teresa O'Shaughnessy, Maura Jo Brennan, M.D., Alicia O.M. Ross, M.D., Julia T. Donovan, M.D., Lori E. Circeo, M.D., Patricia Bailey, M.D., Monica Moriarty, Catherine E. O'Connor, M.D., Ruby Chang, M.D. Samantha Panto, Donna L. O'Shea, M.D., Kerry Panto, Tina Masse, Jean R. Talati, M.D., Cori-Lou Bombard. **Seated Left to Right:** Cassandra Welch, Rhonda Setkewich, Lisa Davis, Audrey Lauren Anton, Heather L. Kofke-Egger, Rayn Harvey, Sarah James. Not pictured: Greer Clarke, M.D.

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The Comprehensive Breast Program at Baystate Medical Center announces the availability of the *Western Massachusetts Breast Cancer Resource Guide*.

The fifty-five page *Resource Guide* provides a brief section on breast cancer facts and lists agencies and services complete with address and telephone number. Included in the *Resource Guide* are national and state breast cancer organizations and support groups. The supplementary services section contains listings of breast cancer resource libraries, breast cancer books, videos and publications and a start-up directory of computer on-line information sources. Additionally, area wig and prostheses suppliers are listed.

Copies may be obtained by calling the Professionals at Baystate Medical Center, 784-2255. The *Resource Guide* is provided free of charge thanks to the sponsorship from the Rays of Hope Walk. ■

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What About AIDS?

SPRINGFIELD, MA–*What About Aids?*, the first national traveling exhibit on the science of HIV/AIDS, will be on display at the Springfield Science Museum from November 2, 1995 through January 28, 1996.

What About AIDS? uses a combination of clear, concise text, personal stories, photo essays, interactive computer programs, video and hands-on components to educate people of all ages. In the fight against AIDS, prevention is the only known way to stop the frightening spread of the virus, and education is the only vaccine.

The exhibit is divided into three major sections:

- **What is HIV/AIDS?** contains scientific information about the virus, the immune system and the history of the epidemic. A special area uses simple language, puzzles and children's stories and drawings to tell parents and children how AIDS is and is not spread.
- **Protect Yourself** assesses risk factors. Visitors can listen to taped interviews with people living with AIDS, talk directly by phone with a national AIDS hotline, and play a dice game to find out how risky behaviors affect the chances of getting HIV.
- **What Can We Do About It?** looks at current AIDS treatment and the world-wide search for a cure. Visitors are encouraged to write down their thoughts and feelings about the disease in a remembrance book which is part of the exhibit.

A number of local AIDS service agencies have been assisting the Science Museum in the planning of educational programs for all age levels to support the exhibit. These agencies will also be providing trained personnel to be available at the exhibit to answer questions from visitors.

What About Aids? at the Springfield Science Museum is supported by Tufts Associated Health Plans, Inc.; WFCR/88.5 FM, Public Radio for Western New England; the Advocate Newspapers; the Community Foundation of Western Massachusetts, Eugene A. Dexter Charitable Fund, administered by BayBank as trustees; and an anonymous gift.

What About Aids? was produced and developed by The Franklin Institute Science Museum for the National AIDS Exhibit Consortium (NAEC)* and funded by the Centers for Disease Control Grant HG2/CCH507214.

The Science Museum is located at the Quadrangle on the corner of State and Chestnut Streets in downtown Springfield, MA. Hours are Wednesday through Sunday, noon-4:00 p.m. Admission is $4.00 for adults, $1.00 for children 6-18, free for children under six and members. Fridays are free with a current Springfield City Library Card. The single admission fee provides entry to all four museums at the Quadrangle. For information, call (413) 733-3871. ■

*The founding members of NAEC are: The American Medical Association; the California Museum of Science and Industry; the Exploratorium; The Franklin Institute; the Maryland Science Center; the Museum of Science and Industry, Chicago, the Museum of Science, Boston; the National Museum of Health and Medicine; and the New York Hall of Science. Circulation of the exhibit is managed by the Association of Science-Technology Centers.

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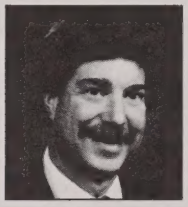

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Arthur W. Price and Michele J. Feinstein, partners in Cohen, Rosenthal, Price, Mirkin & Wernick, have more than twenty-five years of combined experience in representing area physicians in their practices and individually. They counsel solo and group practices in their day to day businesses as well as in their planning for growth or extraordinary concerns. They also advise physicians on personal and family problems.

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THE AIDS FOUNDATION

The AIDS Foundation for Western Massachusetts is a Massachusetts Non-profit Public Benefit Corporation. It is a membership organization for concerned citizens who wish to do something to help People with AIDS and HIV infection.

Founded in 1992, the Foundation has provided emergency assistance funds directly to PWAs in order to ensure their continuity of care, quality of life, and optimum health and well being. Financial assistance, subject to the availability of funds, is directed toward people who have been diagnosed with a disabling condition and who are under severe financial hardship.

Individuals receiving funds at this time must reside in Hampshire or Hampden Counties, and requests for funds are granted only when they are not available from another source. Grants are written directly to the service provider and not to the individual requesting assistance.

The Foundation is overseen by a 21-member Board of Trustees. Over 60 other members of the Corporation serve on the Foundation's standing Grantsmaking, Public Relations, Nomination, Investment, and Fund Raising Committees. Members of the Board of Trustees are nominated from the Membership and elected by the Members for terms set by the By-laws. Members have final authority to amend the By-laws, set the operating budget, adopt policies for the Foundation, and to elect the Board of Trustees. Committee members are also nominated and elected from among the Membership.

One becomes a Member by paying an annual Membership Fee of $10.00, serving on a Standing or Ad Hoc Committee, and providing such other assistance to the Foundation's program as needed.

Dr. Alonzo Sheffield of the Public Health Committee can provide further information on this program for any interested, prospective volunteers. He can be reached through the District Office. ■

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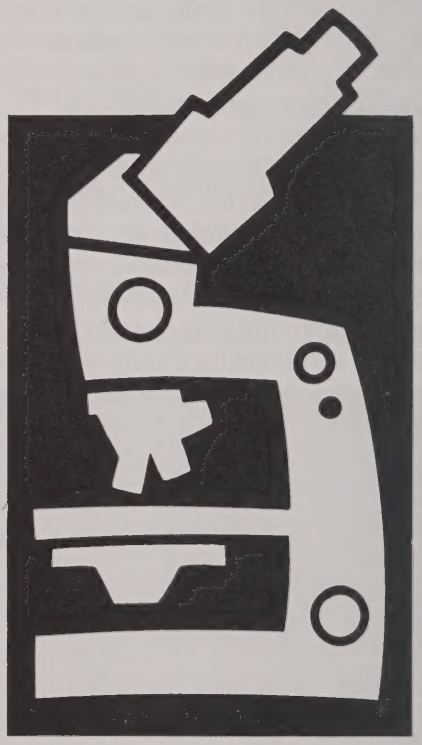

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New Members Welcome

Cathleen Chen, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: March 30, 1963
Premed: Rutgers-State University of New Jersey 1981-1986
Medical: University of Medicine & Dentistry of New Jersey 1986-1990
Internship: Baystate Medical Center 1990-1991
Residency: Baystate Medical Center 1991-1993
Fellowship: Dartmouth-Hitchcock, New Hampshire 1993-1995
Baystate Medical Center 1995-Present
Specialty: Internal Medicine
Fellow

Sherif A. Farag, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: November 8, 1968
Premed: University of North Carolina 1986-1990
Medical: University of North Carolina 1990-1994
Internship: Baystate Medical Center 1994-1995
Residency: Baystate Medical Center 1995-Present
Specialty: Internal Medicine
Resident

David I. Ganz, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: March 7, 1968
Premed: State University of New York, Stonybrook 1987-1990
Medical: State University of New York, Syracuse 1990-1994
Internship: Baystate Medical Center 1994-1995
Residency: Baystate Medical Center 1995-Present
Specialty: Internal Medicine
Resident

Deanne I. Lazer, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: August 6, 1961
Premed: Eastern Michigan University 1979-1982
University of Minnesota 9/1982-12/1982
Purdue University, Indiana 1987-1988
Medical: Indiana University School of Medicine 1988-1992
Internship: Baystate Medical Center 1992-1993
Residency: Baystate Medical Center 1993-Present
Specialty: Anesthesiology
Resident

Elizabeth M. Sutton, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: January 8, 1965
Premed: Tufts University 1983-1987
Howard University Ext., MA 1988-1990
Medical: Georgetown University 1991-1995
Internship: Baystate Medical Center 1995-Present
Specialty: Emergency Medicine
Intern

Mary Gina Trevisani, M.D.
275 Bicentennial Highway
Springfield, MA 01118

Born: February 22, 1964
Premed: Hamilton College, New York 1982-1986
Medical: Albany Medical College, New York 1986-1990
Internship: Albany Medical Center Hospital 1990-1991
Residency: Alton Ochsner Medical Foundation, LA 1991-1994
Fellowship Duke University Eye Center, NC 1994-1995
Specialty: Opthalmology

Continued on next page

New Members Welcome

Continued from previous page

James E. Florek, M.D.
222 Carew Street
Springfield, MA 01104

Born: August 6, 1951
Premed: University of Notre Dame, IN 1969-1973
Medical: Hahnemann Medical College, PA 1973-1977
Internship: Baystate Medical Center 1977-1978
Residency: Baystate Medical Center 1978-1981
Specialty: Internal Medicine/Geriatrics

Michael D. Moran, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: July 5, 1960
Premed: University of California, Irvine 1978-1981
Whittier College, CA 1981-1984
Medical: American University of the Caribbean, Monserrat 1984-1988
Internship: Deaconess Hospital/St. Louis University, MO 1988-1989
Residency: Deaconess Hospital/St. Louis University, MO 1989-1991
Fellowship: Providence Hospital/Wayne State University, MI 1993-1995
Baystate Medical Center/Tufts 1995-Present
Specialty: Internal Medicine/Cardiology/Critical Care
Fellow

Daniel S. Fusco, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: June 27, 1965
Premed: University of Connecticut, Storrs 1983-1986
Worcester Polytechnic Institute 1988-1993
Medical: University of Connecticut School of Medicine 1991-1995
Internship: Baystate Medical Center 1995-Present
Specialty: Internal Medicine/Pediatrics
Intern

Barbara G. Jericho, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: January 10, 1964
Premed: University of Illinois 1981-1985
Medical: Rush Medical College, IL 1985-1990
Internship: Evanston Hospital, IL 1990-1991
Residency: Northwestern University Medical Center, IL 1991-1994
Fellowship: Northwestern University Medical Center, IL 1994-1995
Specialty: Anesthesiology/Pain Management

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Associate Chief of Staff for Ambulatory Care (11A)
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Dawn R. Gertson, M.D.
Chicopee Medical Center
260 New Ludlow Road
Chicopee, MA 01020

Born: October 9, 1958
Premed: Northwest Nazarene College, ID 1976-1980
Medical: Loma Linda University School of Medicine, CA 1980-1984
Internship: St. Vincent's Hospital, Oregon 1984-1985
Residency: St. Vincent's Hospital, Oregon 1985-1987
Specialty: Internal Medicine

Richard W. Whitfield, M.D.
Mary Lane Pediatric Associates
85 South Street
Ware, MA 01082

Born: November 8, 1942
Premed: Brown University, RI 1960-1964
Medical: Harvard Medical School 1964-1966
Duke University School of Medicine, NC 1966-1969
Internship: Baylor College of Medicine Affiliated Programs 1969-1970
Residency: Baylor College of Medicine Affiliated Programs 1970-1971
University of Utah-Department of Pediatrics 1971-1972
Specialty: Pediatrics

Avrimin M. Kogan, M.D.
Noble Hospital
115 West Silver Street
Westfield, MA 01085

Born: January 30, 1959
Premed: New York University 1977-1981
Medical: Rush Medical College, IL 1981-1986
Internship: Booth Memorial Hospital, NY 1986-1987
Residency: Rush Presbyterian Medical Center, IL 1987-1990
Specialty: Anesthesiology/Pain Medicine

John M. Solomonides, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: September 6, 1968
Premed: Tufts University 1986-1990
Medical: University of Massachusetts Medical School 1990-1994
Internship: Baystate Medical Center 1994-1995
Residency: Baystate Medical Center 1995-Present
Specialty: Internal Medicine/Pediatrics
Resident

Carolyn M. Shannon, M.D.
2377 Boston Road
Wilbraham, MA 01095

Born: November 8, 1963
Premed: Providence College, RI 1981-1985
Boston College, MA 1985-1987
Medical: University of Vermont School of Medicine 1988-1992
Internship: University of Rochester, NY 1992-1993
Residency: University of Rochester, NY 1993-1995
Specialty: Internal Medicine

Linda R. Polonsky, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: July 10, 1960
Premed: Wesleyan University, CT 1978-1982
Medical: University of Connecticut School of Medicine 1991-1995
Internship: Baystate Medical Center 1995-Present
Specialty: Obstetrics/Gynecology
Intern

Natalie Savich, M.D.
2341 Boston Road
Wilbraham, MA 01095

Born: June 6, 1966
Premed: Boston University 1984-1988
Medical: University of Pittsburgh School of Medicine 1988-1992
Internship: Baystate Medical Center 1992-1993
Residency: Baystate Medical Center 1993-1995
Specialty: Pediatrics

Fuad F. Mudawwar, M.D.
299 Carew Street #401
Springfield, MA 01104

Born: October 20, 1948
Premed: American University of Beirut, Lebanon 1970
Medical: American University of Beirut 1974
Internship: Amercian University of Beirut 1973-1974 (Pediatrics)
Residency: Amercian University of Beirut 1974-1976 (Pediatrics)
Fellowship: Children's Hospital Medical Center (1976-1978) (Allergy)
Harvard Medical School 1976-1978 (Pediatrics)
Specialty: Allergy/Immunology/Pediatric Allergy

Continued on next page

New Members Welcome

Continued from previous page

Daniel J. Muppidi, M.D.
299 Carew Street #401
Springfield, MA 01104

Born: February 6, 1959
Premed: Osmania Medical College, India 1976-1977
Medical: Osmania Medical College, India 1977-1982
Internship: Osmania University 1982-1983
Residency: Osmania University 1984-1986 (Dermatology) (Osmania General & Ghandi Hospitals)
Fellowship: State University of New York 1992-1994 (Allergy and Clinical Immology)
Specialty: Allergy/Immunology

Patricia P. Petrosky, M.D.
1767 Northampton St.
Holyoke, MA 01040

Born: July 14, 1963
Premed: Mount Holyoke College, MA 1981-1985
Medical: University of Massachusetts Medical School 1986-1990
Internship: Baystate Medical Center 1990-1991
Residency: Baystate Medical Center 1991-1993
Specialty: Pediatrics

Loran W. Roberts, M.D.
70 Court Street
Westfield, MA 01085

Born: June 8, 1957
Premed: Brown University, Rhode Island 1975-1979
Medical: Brown University 1978-1982
Internship: Bridgeport Hospital, CT 1982-1983
Residency: University Hospital, SUNY, Stonybrook 1986-1990
Lehigh Valley Hospital, PA 1990-1991
Fellowship: USA/SR, San Antonio, Texas 1983-1986
Specialty: General Surgery

Brian H. Toole, M.D.
125 Liberty Street
Springfield, MA 01103

Born: January 4, 1954
Premed: Pennsylvania State University 1971-1974
Medical: Temple University Health Sciences Center, PA 1975-1979
Internship: Baystate Medical Center 1979-1980
Residency: Baystate Medical Center 1980-1983
Specialty: Obstetrics/Gynecology

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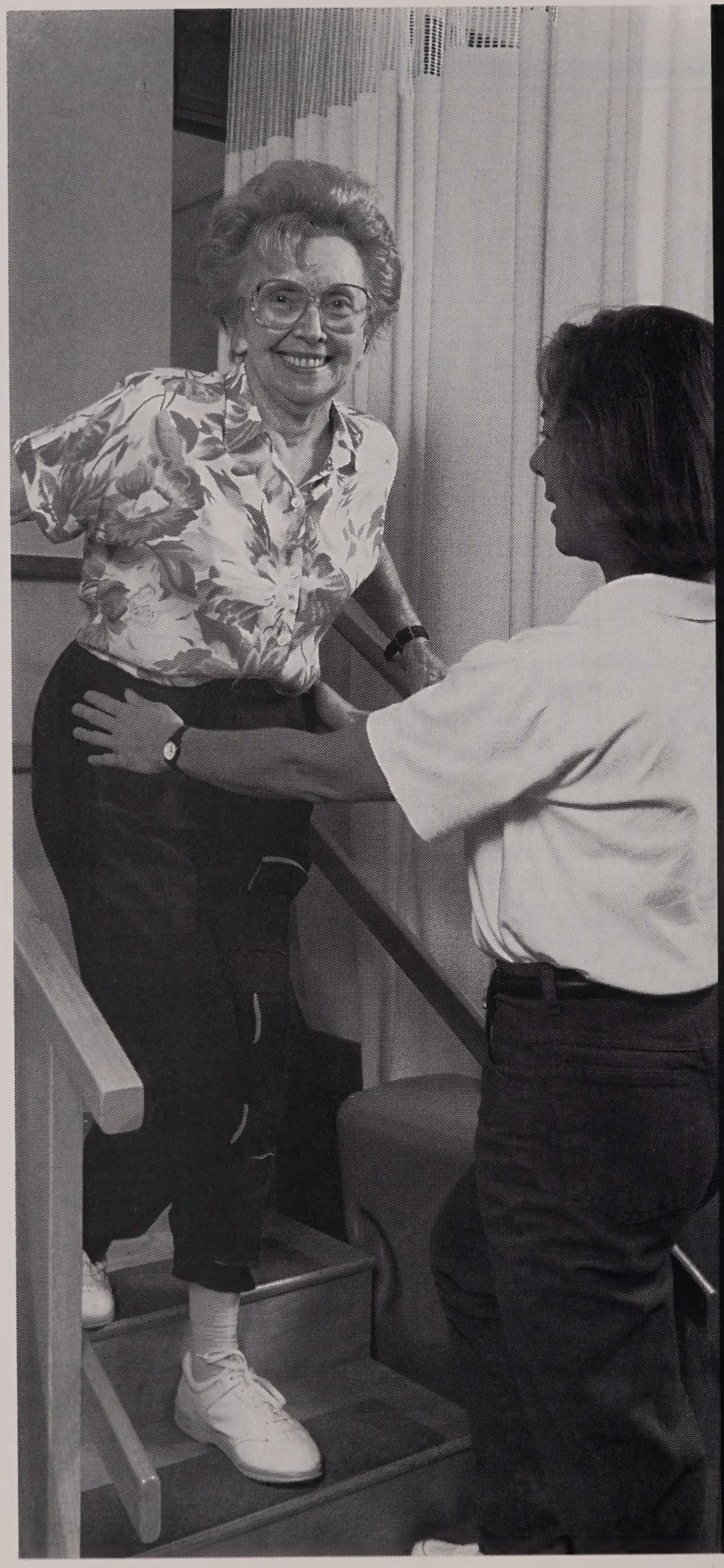

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